Arkansas Family Care Network, Inc.

INFORMATION CHANGE FORM

PATIENT INFORMATION **ACCOUNT #** _____

First Name _____ M.I. _____ Last Name _____

Address _____ Telephone _____

City _____ State _____ Zip _____

DOB _____ Sex _____ Marital Status: **S M W D** SSN _____

Employer _____ Employer Telephone _____

Employer Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY INFORMATION (If other than the patient)

First Name _____ M.I. _____ Last Name _____

Address _____ Telephone _____

City _____ State _____ Zip _____

DOB _____ Sex _____ Marital Status: **S M W D** SSN _____

Employer _____ Employer Telephone _____

Employer Address _____ City _____ State _____ Zip _____

Relationship to patient _____

INSURANCE INFORMATION

Primary Insurance Co _____ Effective Date _____

Address _____ Telephone _____

City _____ State _____ Zip _____

Group # _____ Policy/ID # _____

Insured's Name _____ Relationship Between Patient and Policy Holder _____

Insured's DOB _____ Insured's SSN _____ Insured's Employer _____

Insured's Address _____

Insured's Telephone _____ Copay Amount _____

Secondary Insurance Co _____ Effective Date _____

Address _____ Telephone _____

City _____ State _____ Zip _____

Group # _____ Policy/ID # _____

Insured's Name _____ Relationship Between Patient and Policy Holder _____

Insured's DOB _____ Insured's SSN _____ Insured's Employer _____

Insured's Address _____ Insured's Telephone _____

Tertiary Insurance Co _____ Effective Date _____

Address _____ Telephone _____

City _____ State _____ Zip _____

Group # _____ Policy/ID # _____

Insured's Name _____ Relationship Between Patient and Policy Holder _____

Insured's DOB _____ Insured's SSN _____ Insured's Employer _____

Insured's Address _____ Insured's Telephone _____

****EMERGENCY** Please give the name and telephone number of a friend or relative that *DOES NOT* live at your address**

NAME _____ **TELEPHONE** _____

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE THAT ARKANSAS FAMILY CARE NETWORK, INC. IS PAID FOR SERVICES RENDERED. THIS INCLUDES *LIABILITY* COVERED INJURIES, AS BILLS WILL NOT BE POSTPONED IN ANTICIPATION OF LEGAL SETTLEMENT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

I HEREBY AUTHORIZE ARKANSAS FAMILY CARE NETWORK, INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO ARKANSAS FAMILY CARE NETWORK, INC. ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT.

X_____ DATE_____

(SIGNATURE OF PATIENT OR GUARDIAN)

I,_____, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION:

_____